ORGANIZATIONAL ISSUES IN THE DELIVERY OF HEALTH CARE SERVICES TO OLDER AMERICANS: RESEARCH DIRECTIONS EMERGING FROM AHCPR/NIA CONFERENCE

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Acknowledgments

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TOWARD THE DEVELOPMENT OF A RESEARCH AGENDA ON ORGANIZATIONAL ISSUES IN THE DELVERY OF HEALTH CARE TO OLDER AMERICANS

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The Changing American Health Care System

A number of significant changes are affecting the health care delivery system as a whole, and care for older Americans in particular. As indicated in this supplement, these changes are being driven by multiple factors, including: 1) economic factors, such as increasing cost pressure from both public and private sector purchasers; 2) demographic changes such as the aging and increasing cultural diversity of our population; 3) changes in the causes of morbidity and mortality, especially increases in chronic and other conditions strongly influenced by health behaviors; and 4) continuing advances in technology, defined to include not only medical technology but information and communication technology (see Sofaer, in this Volume).

Restructuring of health care will affect virtually everyone, but older Americans, because they have more medical problems and are often hampered by functional loss as well, are one of the first groups to be greatly affected. ”Health Care Reform” failed as a national initiative in the United States in 1994; nevertheless, the concerns that brought about interest in national Health Care Reform are still active, and are relentlessly bringing about change. For example, States are testing out new delivery and financing systems to maximize health care dollars (Lamphere et al, 1997), and federal legislation, such as the Balanced Budget Act of 1997 (Public Law 105-33, H.R. 2015), which encourages managed care plans for Medicare enrollees, will change the organization and structure of care provided to older people .

With these new trends, the opportunity arises to examine the organizational level effects associated with new health care policies (i.e., how are care structures changing, and with what consequences?). Also to be examined are the effects of changing care structures and the dynamic interplay among older people, their families, and the formal care system in the pursuit of maximum health and functioning in later life.

These questions can be framed within a broad theoretical framework on aging and societal change (Riley, 1994). Rather than focusing exclusively on changes in health care structures, Riley emphasizes the complementary concept of the changing lives of the patients who consume care. According to Riley (1996), older people are active -- not passive -- participants in their own health care; they make choices about their health and decisions about how to use the system. Moreover, as they react to changes in health care structures, patients in turn produce further changes in these systems. Changes in structures and in lives are interdependent dynamisms, continually influencing each other in dialectical interplay (the principle of interdependence). Structures and people change at different rates and at different tempos (the principle of asynchrony), emphasizing that patients are not simply another "level" within the health care system. Asynchrony often produces serious imbalances (or lags) between structures and the needs of patients -- imbalances that can feed back into further changes in the interplay between health care structures and people's lives.

The impact of health care restructuring on older people has been little studied. Previous studies have generally used traditional health care models and focused on economic variables. There has been little application of modern organizational theory to health care for older Americans. Even less attention has been paid to the role of primary care, and how its major attributes (coordination, comprehensiveness, and continuity) fit into organizational theory and practice (Donaldson et al., 1996).

An organizational perspective may prove to offer the best insight into how changes actually affect older people. Such an insight could lead to improved planning and monitoring of future health care.

Development of this Supplemental Issue

In 1996, two government agencies, the Agency for Health Care Policy and Research (AHCPR) and the National Institute on Aging (NIA) teamed up to sponsor a national invitational conference on "Aging and Primary Care: Organizational Issues in the Delivery of Health Care for Older Americans" (AHCPR, 1996). The underlying goal was to examine the potential of an organizational research perspective for expanding the current knowledge base on the determinants of different health care structures and their consequences for older people. This was accomplished by bringing together a group of experts to: 1) review what was currently known about the organization of health care in a changing environment, and 2) develop a national research agenda on organizational issues in the delivery of health care to older Americans. The primary intent of this meeting was to address the full range of factors that shape the behavior of those who produce and use health care services, including the structure, culture, and process of health care organization; the mix, capacities, values and roles played by various health care professionals and agencies; and the interactions between providers and the people they serve.

Approximately 50 persons with expertise in geriatrics, nursing, social and behavioral sciences, and health care management and policy met in Washington, D.C. in March, 1996[1] . The charge to the experts was to respond to working papers that had been commissioned by the two sponsoring organizations on key topics such as critical dimensions underlying different managed care arrangements, intra and interorganizational factors in the delivery of care to older Americans, the role of the consumer in health care delivery, and methodological issues in the conduct of organizational research Since the Conference, the six primary working papers have been reworked to take into account the formal and informal discussions that occurred during the meeting. Unfortunately, there is not space in this supplement to publish the formal discussant remarks. Recognizing the potential values of many of the conference papers, the original conference papers were peer reviewed and revised for publication here in this supplement to Health Services Research.

1 Aside from paper writers who are listed in this Volume, others also contributed to the Conference as session chairs (Kathleen Bond, Linda Siegenthaler, David Lindeman, Jessie Gruman, Anne Foner); formal reactants (Peter Fox, Cheryl Phillips-Harris, John Morris, Mary Pittman, Lois Evans, W. June Simmons, Judith Hibbard, Raynard Kington, Laurence Branch, Andrew Kramer); panelists (Matilda White Riley, Carolyn Clancy, Vincent Mor, Robyn Stone); extramural participants (Patricia Archbold, Donna Cox, David Espino, Carroll Estes, Nancy Harada, Paula Darby Lipman, John McKinlay, Steve Phillips, John Riley, Joan Teno, Frederic Wolinsky, Raymond Robinson); and governmental\foundation representatives (Bruce Craig, Steven Clausner, Anne Gauthier, Richard Hegner, Irene Fraser, Margaret McCardle, Patricia Moritz, Margaret Powell, Lisa Simpson, Susan Solomon, Terrie Wetle. Further information on participants can be obtained from Marcia Ory via e-mail (Marcia_Ory@Nih.Gov).

Overview of Papers

The first paper by Sofaer provides a broad overview of major societal changes which are affecting the health care system as a whole, and thus the delivery of care to older Americans. This overview identifies the short- and mid-term effects of current and emergent changes in health care organizations, as they affect older Americans. It examines economic, demographic, epidemiologic, and technologic trends and their implications for the organization and delivery of health care to older Americans. While the substantial influence of economic factors is acknowledged, a major contribution of this overview is its discussion of how the effects of economic factors on delivery systems are often mediated by concomitant changes in the structure, function and culture of health care. Setting the framework for the research papers to follow, this paper concludes with a useful identification of behavioral and social theories, in particular organizational and interpersonal theories, that are relevant to the examination of trends and their implications.

There is a need for more conceptually-driven articulation of the critical dimensions of managed care arrangements that will help relate key structural characteristics (organizational and economic) both to the delivery of care and to patient responses and outcomes. The second paper by Wholey, Burns and Lavisso-Mourey examines the incorporation of primary care principles (e.g., comprehensive care, continuity of care and attentiveness to social context) into managed care environments. Adding to the growing literature on differences between fee-for-service and managed care arrangements, this paper summarizes differences in access, processes, outcomes and satisfaction. Despite acknowledged challenges to providing primary care for elderly enrollees in managed care organizations, the authors show the potential of managed care organizations for improving the quality of care by highlighting some innovative model programs designed to provide primary care to the elderly. This review demonstrates how different organizing strategies may be used to obtain the same goals, and the importance of specifying the conditions under which different primary care approaches will be most effective. Future research efforts need to examine the determinants and consequences of different managed care arrangements.

The third paper by Zinn and Mor addresses what is currently known about the internal characteristics of individual organizations that deliver health care to older Americans across different practice settings (i.e., ambulatory practices, hospitals, nursing homes, and home health care agencies). It explores existing theory and research that link key internal organizational characteristics (such as size, mission, ownership and managerial communication and control structures) to patient care outcomes. Expanding on the typically cited Donabedian Structure/Process/Outcome Model, these authors also examine the value of contingency theory, which focuses on the mechanisms for communication, co-ordination and control (Leatt and Schneck, 1981), for understanding the impact of intra-organizational structure. Only limited research has been conducted in practice settings other than hospitals. However, this review demonstrates the importance of examining structure-outcome linkages across settings, concluding that what constitutes "good" structure may be outcome and setting dependent, and stressing the need to develop structure and outcome measures appropriate to evolving health care settings.

Interorganizational linkages arise from changes in the environment, and provide opportunity to gain competitive advantage, leverage critical capabilities, increase the flow of innovation, and improve flexibility in responding to market and technological changes. The fourth paper by Kalunzy, Zuckerman, and Rabiner examines the extent and nature of relationships among organizations involved in the delivery of health care to older Americans. These include not only the wide range of individual provider organizations, but also multi-institutional systems of various kinds, insuring organizations (e.g., purchasing alliances and health care insurance providers) and self-insuring employers. After describing the types and forms of interorganizational linkages, the authors present a practical framework for defining and implementing a research agenda on how inter-organizational interactions and linkages influence the delivery of care, patients' responses and outcomes.

Changes in the organization and financing of health care services are expected to influence the ways in which older people interact with the health care system. The fifth paper by Counte discusses decisions, behaviors and preferences of older people and how both the client and the nature of client interactions will be altered by health care system changes currently underway. Highlighting system changes from an acute, medical care approach to a more proactive, health orientation with more emphasis on coordinated care systems/networks, it focuses on health maintenance behavior and the value of existing theoretical models to understand the health behaviors and service utilization patterns of older persons. Unfortunately existing models do not do a very good job of integrating behavioral, familial, and economic variables. While there is general consensus on the unprecedented changes in the health care system, there are still many unknowns about how the older client will fare in our changing health care environment. For example, additional research is needed to document whether older people will actually become more active consumers in the evolving health care system, and the extent to which changing health structures will be responsive to the special needs of older clients.

There are critical methodological problems and barriers in conducting rigorous conceptually-driven research on organizational and patient factors in the delivery of primary care to older Americans. Problems include issues in operationalizing and measuring key concepts; accessing relevant secondary data; defining the unit of analysis; achieving sufficient statistical power where the unit of analysis is an organization or a network of organizations; and developing designs and statistical techniques that take into account the nesting of multiple variables with different units of analysis. The paper by Fennel and Flood focus on three key challenges raised in this set of papers: 1) selecting an appropriate "level" or unit of analysis; 2) reframing traditional models of service delivery to reflect changing health care system actors and boundaries; and 3) reconceptualizing the outcomes of care to reflect better the realities of caring for older people. Suggesting new methodological approaches for assessing changing organizational structures, aging populations, and their complex interactions, this paper helps address some of the most challenging problems faced today by health services researchers.

A common theme across these six papers is the unprecedented change in today's health care system, making the examination of antecedents and consequences of organizational changes critical but challenging. New theories and methods are required to further current research

efforts.

Identification of Research Priorities

One of the primary objectives of the Conference was to delineate a research agenda that could guide and inform practitioners and policy makers , and further knowledge of health care delivery issues. The following section identifies some key research recommendations made by paper presenters, reactants, and panelists, along with those of other conference participants who were asked to identify their three major research issues. For a complete list of research recommendations, see the identification of research priorities in the Conference Summary Report (Lipman, Cox, and Ory, 1996).

Managed Care and the Changing Health Care Environment

Given the inconsistent findings and/or lack of findings related to managed care models classified as for-profit or non-profit, for example, differences between managed care types might be better recognized if there is less emphasis on comparisons based on traditional health care organizational classifications (e.g., a HMO versus Fee-for Service dichotomy).

- Research comparisons should focus on managed care structure types that will provide greater understanding of differences among managed care organizations, and between managed care organizations and more traditional delivery systems. Research efforts should relate these structural or organizational components of managed care to differential outcomes in older people.

- Greater emphasis should be placed on studies that assist in identifying, understanding, and predicting how managed care has altered, is altering, and will be altered by the forces in the health care environment.

- Research is needed to identify and examine the impacts of Medicare /Medicaid enrollment in HMOs. Areas of study include but should not be limited to: Access, program costs, and quality of services; Effects on health behavior and attitudes; Out-of-pocket expenses, service outcomes, and continuity of care; Care coordination and aspects of this intervention that may account for differences in outcomes (e.g., costs, quality, etc.).

Intraorganizational Factors Affecting the Delivery of Primary Care to Older Americans

Research is needed on how the restructuring of the health care system and change in the health care workforce affect provider-patient relationships, continuity of care, and communication between providers. Special attention should be focused on:

- The impact of structural/organizational factors on provider attitudes and behaviors and how these factors relate to the quality of care provided and its outcomes.

- How utilization, access, and select outcomes are affected by integrated delivery systems in

their various stages of development. For example, what are the organizational priorities at various stages and what impact do these changing priorities have on primary care to the elderly?

- Primary vs. specialty geriatric care and how recommendations of geriatric assessment unit teams are implemented and maintained. For example, do differences in the timing of referral have differential outcomes on patient health or satisfaction, or on provider attitudes and behaviors?

- The variation in utilization of services by culturally and ethnically diverse populations, and economically and socially isolated older persons; examination of barriers and enhancers to primary care for these at-risk groups.

Interorganizational Factors Affecting the Delivery of Primary Care to Older Americans

Managed care is intended to improve integration, with one mark of integration being the rate of "transition" from one post-acute setting to another. Research is needed to identify the "successful" quality integrated system and the inter-organizational relationships that are integral to its success. Examples of areas of study include:

- Defining the elements and measuring the relationships and interaction among primary care providers of integrated systems to determine effect on the provision of primary care.

- The identification of highly effective systems for insight into elements of organization and structure, decisional processes, and linkages among component subsystems that predict good outcomes for older people.

- How transitions in the health care delivery system can maintain or enhance the most effective components of each organization, and the impact of transitions on care for the elderly?

- Examination of the differences in cost and quality outcomes, including provision of care for chronic illness and use of services during last year of life, for patients in totally integrated systems with a gerontologic focus compared to those in fee-for-service and other managed care models.

The Older Client and Providers in a Consumer-Centered Health Care Environment

Research is needed on the elderly and disabled health care consumer and their behavioral responses to health educational strategies and information campaigns. Examples include:

- Ways to give clients and their caregivers more control/influence over the delivery systems and their own care. This includes research on how older clients will respond to new aspects of the doctor-patient relationship, including the effectiveness of the primary care physician as "gatekeeper" to access to specialty care, increased use of physician extenders, and fewer visits with shorter encounters. Studies also need to focus on identification of the roles and

contributions of family members in health care decisions in a managed care environment.

- Dissemination of health information to minority older adults and how this information leads to decisions about health care or outcomes of health care.

- Structural and process factors related to the dissemination of clinical and/or quality information to providers as well as their responses to this information.

Methodological Issues in the Study of Primary Care Delivery to Older Adults

Given the changes that are occurring in the health care environment as well as the policy environment, researchers must consider issues related to the usefulness of existing datasets, the public availability of databases, the creation of new, research driven data bases (e.g., medical record abstraction), and how to devise efficient linking mechanisms for merging datasets at different levels (e.g., HCFA, AHA, clinical data, etc.). In the face of major change, research attention must be given to:

- The development of a comprehensive set of outcome measures across all domains that are universal and may be applied across patient, organization, system, and community settings.

- Methodologies and strategies for studies at the event/micro or patient/provider level, transitions across care settings, and the operationalization of patient/ provider interactions.

- Conducting longitudinal studies over fixed intervals of time using comprehensive outcome measures in both traditional and emerging settings.

This presentation of research priorities parallels the topical organization of issues presented at the 1996 Conference. It is important to note that there are many cross cutting issues, such as attention to the growing diversity in the older population; the potential impact of cohort effects; and key utilization processes (e.g., referral patterns; continuity of care; and disenrollment practices). This Volume brings together experts in aging and primary care with the intent of enhancing research at this important interaction. The papers which follow will elaborate on health care trends, their implications for older people's health and quality of care, and critical research needs and gaps.

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